86-1986

Supreme Court, U.S.
FILED
MAY 26 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 86-

# In The Supreme Court of the United States

OCTOBER TERM, 1986

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NORTH BROWARD HOSPITAL DISTRICT,
*Petitioner,*

*v.*

OTIS R. BOWEN, M.D., Secretary,
of Health and Human Services,
*Respondent.*

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## PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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## QUESTION PRESENTED FOR REVIEW

The question presented for review, as to which the Courts of Appeals are in conflict, is:

> Whether a medicare provider which "self-disallows" costs in its cost report in a good faith effort to comply with Medicare regulations retains a right to review of those costs by the Provider Reimbursement Review Board pursuant to 42 U.S.C. § 1395oo?

A necessary subquestion is whether the court's construction of the Medicare statute to deny a right to be heard under such circumstances is contrary to the presumption favoring judicial review as enunciated in *Bowen v. Michigan Academy of Family Physicians,* 106 S.Ct. 2133 (1986)?

## LIST OF PARTIES

The parties to the proceedings below were the petitioner, North Broward Hospital District, and the respondent, Otis R. Bowen, M.D., Secretary of Health and Human Services.

The North Broward Hospital District is a special tax district created by the Legislature of the State of Florida to own and operate hospitals within the geographic area of the district, *i.e.*, certain portions of Broward County, Florida. The North Broward Hospital District operates three public hospitals, Broward General Medical Center, North Broward General Medical Center, and Imperial Point Medical Center.

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## PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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**The petitioner, North Broward Hospital District, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eleventh Circuit.**

## OPINIONS BELOW

The opinion of the Court of Appeals for the Eleventh Circuit is reported at 808 F.2d 1405, and is reproduced in the appendix hereto, p. A-3, *infra*. The District Court's Order of Remand to the Provider Reimbursement Review Board and Magistrate's Report and Recommendation in *North Broward Hospital District v. Margaret M. Heckler, Secretary of Health and Human Services*, Case No. 84-6737-CIV-HASTINGS (S.D. Fla. 1985) are unreported and are reproduced in the appendix hereto, p. A-9, *infra*.

The decisions of the Provider Reimbursement Review Board and of the Deputy Administrator are reproduced in the appendix hereto, p. A-16, *infra*.

## JURISDICTION

The decision of the Court of Appeals for the Eleventh Circuit sought to be reviewed was issued and entered on January 12, 1987. The petitioner herein timely filed a Petition for Rehearing and Suggestion For Rehearing *En Banc*. On February 25, 1987 the Petition For Rehearing was denied.

The jurisdiction of this Court to review the judgment of the Eleventh Circuit is invoked under 28 U.S.C. § 1254(1).

## STATUTE INVOLVED

42 U.S.C. § 1395oo. Because of its length, pertinent portions of the statute are reproduced in the Appendix, pp. A-38-A-40.

## STATEMENT OF THE CASE

The petitioner's hospitals provide inpatient hospital service to Medicare beneficiaries, pursuant to a "provider agreement" with the Secretary of Health and Human Services ("Secretary"). At the end of each cost year, a provider must submit its cost report to its Medicare fiscal intermediary, which is generally a private insurance company that has a contract with the Secretary. The fiscal intermediary reviews and audits the cost report, and issues a Notice of Program Reimbursement (NPR) indicating the total amount of Medicare reimbursement due. If a provider is dissatisfied with the amount of reimbursement it receives, and the amount in controversy is $10,000 or more, it may file an appeal with the Provider Reimbursement Review Board ("Board").

The petitioner's hospitals each filed the required cost reports for the fiscal year ended June 30, 1977. Included in each cost report were fees paid to the Broward County tax assessor and tax collector for services provided to the petitioner. Although these fees were included in the cost report, they were subtracted as an unallowable cost for purposes of claiming reimbursement. This "self-disallowing" was based on a belief that such costs would not be reimbursable under applicable Medicare regulations. Neither the statute, the regulations nor any instructions require that a provider must

violate a regulation and claim costs which may not be permitted under that regulation in order to test the merits of a claim for reimbursement for a particular cost.

The Board initially accepted jurisdiction of the appeals filed by the petitioner's hospitals contesting the amount of reimbursement set forth in their respective NPR's for 1977. These appeals included claims for reimbursement for the tax assessor and tax collector fees incurred during 1977. However, the Board later changed its position and held that it did not have jurisdiction over the fees because they were not claimed for reimbursement in a cost report and therefore were not included in the disallowed costs of the NPR's. The Board's position was affirmed by the Deputy Administrator, Health Care Financing Administration, with regard to two of the petitioner's hospitals.

The petitioner appealed the Board's denial of jurisdiction to the district court, pursuant to 42 U.S.C. §1395oo(f)(1). The district court reversed the decision that the Board lacked jurisdiction, holding that where costs were self-disallowed in a cost report in a good faith effort to comply with Medicare rules, the Board may assume jurisdiction to hear the issues raised thereby. The district court then remanded the case to the Board.

The court of appeals reversed the decision of the district court. The court of appeals held that in order to retain the right to appeal a decision on whether a cost is reimbursable, the hospital must either expressly claim reimbursement in its cost report or specifically contest the non-allowability of the item with its intermediary in or with the cost report. In so holding, the court adopted the analysis of the Court of Appeals for the D.C. Circuit in *Athens Community Hospital, Inc. v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982) (*Athens* I), *modified*, *Athens Community Hospital, Inc., v. Heckler*, 743 F.2d 1, (D.C. Cir. 1984) (*Athens* II).

## REASONS FOR GRANTING THE WRIT

### I. A Conflict Among Circuit Courts of Appeals Exists as to the Proper Interpretation of the Medicare Jurisdictional Statute.

Seven courts of appeals have addressed the question whether, under § 1395oo, the Provider Reimbursement Review Board has jurisdiction to hear self-disallowed claims. To date, four different and distinct answers have been given to the question.

The Seventh Circuit, in *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983), held that the Board does have jurisdiction to hear self-disallowed claims. The court found that the language of § 1395oo(d) "vests broad authority" in the Board, and concluded that "since the statute allows the Board to consider matters outside of the cost report," 698 F.2d at 1346, the Board can hear self-disallowances.

The District of Columbia Circuit, in *Athens* II, reached the contrary conclusion. The court found that the language of § 1395oo(d) creates two separate and independent grants of jurisdiction: 1) to review decisions made by the fiscal intermediary and 2) to make any other revisions. 743 F.2d at 4. However, the court went on to conclude that the second grant can only be exercised if necessary to accommodate any decisions made under the first grant of power, and does not give the Board independent authority to hear self-disallowances. 743 F.2d at 9. Central to the court's rationale was the notion that the intermediary's analysis and conclusions on the claims are essential to the Board's determination. 743 F.2d at 6-7. The Sixth Circuit in *Baptist Hospital East v. Secretary of Health and Human Services*, 802 F.2d 860 (6th Cir. 1986) and *Bethesda Hospital Association v. Bowen*, 810 F.2d 558 (6th Cir. 1987), *cert. appl. for* May 2, 1987, and the Fourth Circuit in *Community Hospital of Roanoke Valley v. Health and Human Services*, 770 F.2d 1257 (4th Cir. 1985), essentially adopted the *Athens* decision and held that the Board cannot hear self-disallowed claims.

The First Circuit arrived at yet a third reading of the statutory language. In *St. Luke's Hospital v. Secretary of Health and Human Services*, 810 F.2d 325 (1st Cir. 1987), the court held that the language of § 1395oo(d) is clear and unambiguous in giving the Board the power to hear all "matters covered by [the] cost report", including self-disallowed claims. But the court went on to hold that this power is discretionary, and that it is up to the Board whether that power should be exercised in a given case.

The Eleventh Circuit added yet another variable in the determination of whether self-disallowed costs may nevertheless be claimed for reimbursement before the Board. In *Tallahassee Memorial Regional Medical Center v. Bowen*, No. 85-3839 (11th Cir. 1987), May 5, 1987, a panel of the Eleventh Circuit (one judge dissenting) held that hospitals which sought to challenge a regulation disallowing certain costs pursuant to 42 U.S.C. § 1395(f)(i) could do so even though such costs were not claimed on a cost report. The Eleventh Circuit panel in *Tallahassee Memorial* distinguished the panel decision in the instant case on the ground that *Talahassee Memorial* involved a grant of judicial review specifically enacted by Congress to challenge the validity of a regulation which the Board does not have the power to overrule or refuse to follow. In essence, the 11th Circuit has sanctioned review of a self-disallowed cost when the failure to include the cost as reimbursable on the cost report is due to the provider's seeking to have a regulation held invalid while on the instant case it has denied review for providers that have failed to claim a cost in the cost report in a good faith effort to comply with the medicare rules, but who seek an interpretation of a regulation rather than challenge its validity in the first instance.

Most recently, the Ninth Circuit squarely rejected the *Athens II* rationale and held that the Board clearly has jurisdiction to hear claims for reimbursement for self-disallowed costs. *Adams House Health Care vs. Heckler*, No. 85-1512 (9th Cir. May 18, 1987).

The result of this split among the circuits is that whether the Board will hear self-disallowed claims not raised with the intermediary as a contested claim prior to issuance of the NPR now depends on where the provider is located. If it is located in the Seventh or Ninth Circuits, the answer is yes; if in the District of Columbia, the Fourth, or Sixth Circuits, the answer is no; if in the First Circuit, the answer is maybe, depending on the case-by-case discretion of the Board; if in the Eleventh Circuit, the answer is yes or no depending on whether the hospital seeks to bypass the Board by claiming a regulation is invalid.

## II. The Decision Below Conflicts with a Previous Decision of this Court.

In *Bowen v. Michigan Academy of Family Physicians,* 106 S. Ct. 2133 (1986), this Court emphatically affirmed the strong presumption favoring judicial review of agency actions in the Medicare context. Citing the legislative history of the Administrative Procedure Act, the Court acknowledged that only upon a clear and convincing showing of legislative intent to restrict access to review may those aggrieved by agency action be denied judicial review of their claims. 106 S.Ct. at 2136.

The effect of the interpretation given the Medicare statute by the court below is to deprive the petitioner's hospitals of their right to an administrative and judicial review of their claims, despite the fact that they have met all the express requirements Congress specified in §1395oo(a) for entitlement to such a hearing (i.e., they filed cost reports, they are dissatisfied with the amounts of their NPRs, they appelaed to the Board within 180 days, and the amounts in controversy exceed $10,000). Where Congress has not expressly stated that a dispute must first be raised with the intermediary as a prerequisite for entering the administrative appeals process, the reading of such a restrictive requirement into the statutory language is contrary to interpreting a remedial statute in accordance with the presumption favoring judicial review. Such a reading is inconsistent with *Michigan Academy.*

## III. This Issue Involves the Requisite Public Importance to Medicare Providers Throughout the Nation.

The question whether the Board has jurisdiction to hear self-disallowed claims affects all types of Medicare providers throughout the country that seek access to the administrative and judicial review process through the Provider Reimbursement Review Board. These providers include hospitals, skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

For hospitals, this issue continues to be important even with the advent of the Medicare prospective payment system (PPS) (effective October 1, 1983), under which hospitals receive a fixed amount per Medicare discharge, depending on the patient's diagnosis. First, those hospitals exempt from PPS (e.g., children's hospitals, psychiatric hospitals) still receive cost reimbursement on the basis of their filed cost reports, and all their costs are subject to appeal to the Board. Second, those hospitals covered by PPS receive, for the first four years, interim rates based in part on a cost report filed in an earlier "base year", generally fiscal year 1982. Disputes concerning the base year cost report (including the self-disallowing issue) are still in the administrative and judicial review process, and the result of those appeals will affect the hospitals' PPS rated. And third, these PPS hospitals continue to receive reimbursement for certain costs on a cost basis, which depends on the filing of cost reports in each PPS year. The self-disallowance issue can arise in any of these years.

In addition, all non-hospital providers are cost-reimbursed based on filed cost reports, and are entitled to appeal their cost reimbursement disputes to the Board. The self-disallowance issue can arise in any of these appeals.

## CONCLUSION

For the foregoing reasons, this petition for a writ of certiorari should be granted.

Respectively submitted,

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# APPENDIX

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# United States Court of Appeals

FOR THE ELEVENTH CIRCUIT

No. 85-6039

Jan. 12, 1987

NORTH BROWARD HOSPITAL DISTRICT,
*Plaintiff-Appellee,*

v.

OTIS R. BOWEN, Secretary of the United States Department of Health and Human Services,
*Defendant-Appellant.*

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**Appeal from the United States District Court for the Southern District of Florida.**

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Before JOHNSON and ANDERSON, Circuit Judges, and GARZA*, Senior Circuit Judge.

GARZA, Senior Circuit Judge:

This case presents a difficult statutory construction question as to whether a Medicare provider may claim certain costs in a proceeding before the Provider Reimbursement Review Board when the provider failed to claim such costs or otherwise contest them in its annual Medicare cost reports. The Provider Reimbursement Review Board ("PRRB" or "Board") held that it had no jurisdiction to consider reimbursement claims not expressly claimed by the providers in the cost report to the fiscal intermediary. The district court remanded the case to the Board, directing the Board to consider costs not expressly claimed within the cost report. We vacate the district court's order of remand and uphold the Board's decision that it had no jurisdiction to consider the claims of the provider in this case.

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* Honorable Reynaldo G. Garza, Senior U.S. Circuit Judge for the Fifth Circuit, sitting by designation.

## I

In 1965, Congress enacted Title XVIII of the Social Security Act, known today as the "Medicare" program, 42 U.S.C. § 1395 *et seq.* This legislation authorizes federal reimbursement for medical care provided to the aged and certain disabled individuals. Part A, under which this case arises, provides hospital insurance benefits to the elderly. If the health care provider agrees not to bill certain patients for medical services, the Act mandates that the provider be reimbursed for its "reasonable costs" of providing medical services to medicare beneficiaries. 42 U.S.C. §§ 1395f, 1395cc. Annual cost reports are submitted to a "fiscal intermediary" for review; the fiscal intermediary acts as an agent of the Secretary of Health and Human Services (HHS) and is responsible for reviewing claims for reimbursement and administering payments due under the program. 42 U.S.C. § 1395h. The intermediary audits the annual cost report of the provider and issues a Notice of Program Reimbursement (NPR) to the provider with an explanation of any audit adjustments or disallowed costs. If the provider is dissatisfied with the final determination of the intermediary, it may appeal to the Provider Reimbursement Review Board ("PRRB" or "Board"). A provider may "obtain a hearing with respect to such cost report" before a PRRB if the provider

> is dissatisfied with the final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this sub-chapter for the period covered by such report."

42 U.S.C. § 1395*oo*(a)(1)(A)(i). Once the matter is before the PRRB, the Board has

> the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of

services) even though such matters were not considered by the intermediary in making such final determination.

42 U.S.C. § 1395*oo*(d). The statute authorizes a provider to seek review of a PRRB decision by the Secretary, and if the Secretary's decision is also adverse, the provider may seek judicial review of the Secretary's final decision. 42 U.S.C. § 1395*oo*(f)(1).

## II

The North Broward Hospital District (North Broward) exists in a special tax district created by an act of the Florida legislature. North Broward operates three public hospitals in Broward County; these hospitals are providers under the Medicare program. As such, the hospitals receive interim payments at least monthly from the Medicare program based on the estimated cost of health-covered services provided to Medicare beneficiaries.[1] Final settlement is made retroactively based upon annual cost reports which North Broward submits to a claim intermediary for reimbursement of actual expenditures.

During fiscal year 1977, North Broward incurred costs consisting of charges by the Broward County tax assessor and Broward County tax collector for revenue necessary to operate the three hospitals. The hospitals initially included these costs in their individual cost reports but later "self-disallowed"[2] them. Since North Broward's cost report did not request reimbursement for its tax payments, the fiscal intermediary did not include the tax collection costs in its NPR, and there were no payments made to North Broward for the tax collection expenses.

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[1] The periodic interim payments are designed to assist the providers in avoiding cash flow problems. 42 U.S.C. § 1395g.

[2] "Self-disallowed" costs are expenses listed in an annual cost report but are not costs for which a provider claims it is entitled to reimbursement. Since these costs of health care are initially listed and then voluntarily subtracted by the health care provider itself and not claimed for reimbursement, they are commonly termed "self-disallowed" costs. North Broward offers no explanation as to why these costs were self-disallowed.

North Broward appealed the intermediary's determination of reimburseable costs to the PRRB and, for the first time, raised a claim for reimbursement of the tax collection expenses while on appeal before the PRRB. The Board initially accepted jurisdiction of North Broward's appeal, but on June 28, 1984, the Board informed North Broward that it could not accept jurisdiction over the assessment and collection expenses because they were not claimed as costs in the provider's original cost reports. On internal agency appeal, the acting deputy administrator of the Health Care Financing Administration affirmed the decision denying jurisdiction on August 23, 1984; this constituted the final decision of the Secretary of Health and Human Services. North Broward appealed the Secretary's decision by filing suit in U.S. District Court. Judge Alcee Hastings determined that the tax collection costs were "self-disallowed" in a good faith attempt to obey the law. He dismissed the case without prejudice and remanded it to the PRRB, holding that the PRRB did have jurisdiction to hear issues concerning self-disallowed costs not expressly claimed in an initial cost report. The Secretary appeals that decision.[3]

## III

Crucial to the resolution of this issue is our interpretation of the Medicare statute. Our standard of review turns on whether the Secretary's interpretation of the law is reasonable or arbitrary and capricious; courts grant the agency charged with the administration of a statute substantial deference in its interpretation. *Blum v. Bacon,* 457 U.S. 132, 102 S.Ct. 2355, 72 L.Ed.2d 728 (1982); *Memorial Hospital v. Heckler,* 706 F.2d 1130, 1134 (11th Cir. 1983) *cert. denied,* 465 U.S. 1023, 104 S.Ct. 1275, 79 L.Ed.2d 680 (1984); *Lloyd Noland Hospital and Clinic v. Heckler,* 762 F.2d 1561 (11th Cir. 1985) (the court "will not substitute its

[3] The initial question, of course, is whether this is an appealable order since there was no adjudication on the merits. This Circuit has held that a remand order from a district court to the PRRB is an appealable order. *Medical Center Hospital v. Bowen,* No. 86-3026 (11th Cir. March 6, 1986).

judgment for that of the agency"). Absent a clear error of judgment, the agency's construction should be upheld.

Four United States Circuit Courts have previously considered the Secretary's interpretation of 42 U.S.C. § 1395*oo*. The District of Columbia Circuit filed two opinions holding that a provider must raise a claim in its original cost report or lose its right to claim the cost on appeal. *Athens Community Hospital v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982) (*Athens I*); *modified on reh'g, Athens Community Hospital v. Schweiker*, 743 F.2d (D.C. Cir. 1984) (*Athens II*). The Fourth Circuit has also adopted the Secretary's position and the rationale of *Athens II*. *See Community Hospital of Roanoke Valley v. Health & Human Services*, 770 F.2d 1257 (4th Cir. 1985). The Sixth Circuit's decision in *Saline Community Hospital v. Secretary of Health & Human Services*, 744 F.2d 517 (6th Cir. 1984), affirmed this reading of the statute. The Seventh Circuit has found contrary to the Secretary, *St. Mary of Nazareth Hospital v. Dept. of Health & Human Services*, 698 F.2d 1337 (7th Cir.1983), as have some district courts.[4] After a close reading of the Medicare statute and considered review of the previous decisions on this issue, we are persuaded that the Secretary's interpretation is reasonable and should be upheld.

The conflict over the interpretation of the Medicare statute concerns whether or not a provider must expressly claim or specifically contest an item of reimbursement with the fiscal intermediary before such cost(s) may be claimed on appeal to the PRRB. Under the Medicare statute, the PRRB has the power only to review "matters covered by such cost report." 42 U.S.C. § 1395*oo*(d). However, § 1395*oo*(d) also provides that the Board shall base its decision upon "the record made at such hearing, which shall include the evidence considered

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[4] *See, e.g., Adams House Health Care v. Heckler*, 604 F.Supp. 110 (N.D.Cal.1984) *appeal docketed*, No. 85-1512 (9th Cir. Jan. 7, 1985); *Parkway Memorial Center, et. al. v. Heckler*, No. 83-1700-CIV (S.D. Fla. Sept. 19, 1984) *reconsideration denied* (S.D. Fla. Dec. 18, 1984). *Springdale Memorial Hospital v. Heckler*, —F.Supp.—No. 85-5066 (W.D.Ark. April 14, 1986) (order that receipt of NPR not required for appeal of prospective payments to the PRRB).

by the intermediary and such other evidence as may be obtained or received by the Board...even though such matters were not considered by the intermediary in making such final determination." *Id.*

The language of the statute is ambiguous as to whether the PRRB can consider reimbursement claims not disclosed in the cost report. While there are various methods of interpreting the statutory grant of § 1395*oo*(d)[5], the D.C. Circuit reasoned that "there is only one way of reading the statute that does give effect to both charges of Section 1395*oo*(d)."[6] *Athens II*, 743 F.2d at 9; *accord, Community Hospital of Roanoke Valley*, 770 F.2d at 1262. A cost report lists both reimburseable and non-reimburseable costs; there is clearly a difference between simply listing a cost on a provider's cost report and claiming reimbursement for a particular cost incurred. The fiscal intermediary only audits costs expressly claimed for reimbursement. It would be anomalous for a

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[5] See the thorough analysis of possible interpretations in *Athens II*, 743 F.2d 1, 4-7.

[6] This conclusion is instructive. *Athens II* modified *Athens I* because the first panel opinion focused too much on the "matters covered in such cost report" language instead of attempting to harmonize and give meaning to both of the potentially conflicting provisions of § 1395*oo*(d). Neither clause, "matters covered in such cost report" nor "even though such matters were not considered by the intermediary in making such final determination," can be read without reading tothe entire statutory section in context.

This illustrates the problem with the decision in *St. Mary of Nazareth v. Dept. of Health & Human Services*, 698 F.2d 1337 (7th Cir. 1983), the only appellate decision allowing reimbursement claims to be raised for the first time before the PRRB. The Seventh Circuit's view of § 1395*oo*(d) places predominant weight on a single clause of the statute, the "even though.." phrase, and fails to properly consider the entire statutory section or the overall regulatory scheme created by Congress. The reimbursement review procedure is modeled after the civil litigation procedure, and the PRRB's review of the fiscal intermediary's decision is limited in the same manner as an appellate court's review of a trial decision: the claim had to be brought at the initial hearing to be recognized on appeal. To the extent § 1395*oo*(d) allows evidence of claims not considered by the intermediary, we adopt the D.C. Circuit's conclusion that such evidence is limited to the *category* of claims previously filed in the cost report. *See Athens II*, 743 F.2d at 3, n. 2

North Broward stated during oral argument that the self-disallowed tax payments at issue here were listed as general administrative expenses. Appellee has made no representation that such general expenses were costs claimed for reimbursement. The actual cost report has not been made a part of this record.

provider to be "dissatisfied" with the decision of the fiscal intermediary because the provider itself failed to disclose costs for which it desired reimbursement. The only plausible construction of § 1395*oo*(d) requires that an expense be overtly disclosed and contested before the fiscal intermediary in order to be "a matter covered by such report" and appealable before the PRRB; the Board may consider "revisions" on the reimbursement of costs "even though such matters were not considered by the intermediary in making such a final determination" so long as such revisions "[are] necessary to accommodate other PRRB revisions of matters that were [expressly] claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB." *Athens II*, 743 F.2d at 9. A broader reading of PRRB jurisdiction, allowing any claim to be raised for the first time on appeal to the Board, "would effectively nullify the language in the statute that limits the PRRB's authority to affirm, reverse or modify reimbursements to 'matters covered by a cost report' " and wreak havoc with the multi-tiered administrative appeals scheme. *Athens II*, 743 F.2d at 6. The district court's reading would result in the elimination of the administrative review process clearly provided for in the Medicare statute and regulations.

We believe that the scope of jurisdiction conferred by § 1395*oo*(d) is limited to matters put into dispute by the provider at the time the cost report is filed. This reading of the statute is more consistent with the language of § 1395*oo*(d) and with the overall approach contemplated by Congress. *See* 42 U.S.C. § 1395*oo*. Therefore, we hold that a provider, to retain the right to appeal the decision on whether a cost is reimburseable, must either expressly request reimbursement for a cost item in its initial cost report or specifically contest the non-allowability of the item with its intermediary in or with the cost report.[7]

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[7] Of course, the Medicare reimbursement scheme also provides other avenues of appeal to request reimbursement. A thirty-day extension of the due date for a cost report may be granted for good cause. 42 C.F.R. § 405.453(f)(2)(ii). The intermediary has the discretion to allow or require a provider to reopen and, if appropriate, amend a previously filed cost report. 42 C.F.R. §§ 405.453(f), 405.185. Moreover, the provider could always "self-disallow"

*(footnote continued on next page)*

The decision of the district court is hereby VACATED and the appeal DISMISSED.

ANDERSON, Circuit Judge, concurring.

In my opinion, the most reasonable interpretation of the statute is contrary to that urged by the Secretary. The language, "power . . . to make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary," would seem rather clearly inconsistent with that interpretation, and would seem to specifically address the issue in this case. However, Judge Garza's opinion has persuaded me that the Secretary's interpretation is not so strained as to be unreasonable, arbitrary or capricious. Accordingly, deference to the agency's construction is due. I concur in the judgment.

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*(footnote continued from preceding page)*

costs but append a letter to the cost report stating that such voluntary self-disallowance was performed only to comply with regulations which the provider wished to challenge. *See Community Hospital of Roanoke Valley*, 770 F.2d at 1263, n. 4.

# United States District Court

FOR THE

SOUTHERN DISTRICT OF FLORIDA

CASE NO. 84-6737-CIV-HASTINGS

NORTH BROWARD HOSPITAL DISTRICT,

*Plaintiff,*

*v.*

MARGARET M. HECKLER,

*Defendant.*

ORDER OF REMAND TO THE PROVIDER REIMBURSEMENT REVIEW BOARD

(Filed, October 2, 1985)

THIS CAUSE is before the court on the Magistrate's Report and Recommendation of August 2, 1985, to which objections were filed by the Defendant on August 19, 1985. Thereafter, the Plaintiff moved to compel administrative review pursuant to the Magistrate's findings and conclusions that: 1) the Plaintiff has standing to bring this action, and 2) under Section 1395oo(d), the Provider Reimbursement Review Board (PRRB) is empowered to consider matters outside cost reports. Defendant's opposition to Plaintiff's motion to compel administrative review is based on the opinion that a remand is unwarranted and inconsistent with the requirements of the Federal Rules.

The court has independently reviewed the entire file. It is thereupon ORDERED AND ADJUDGED that:

1. Where a provider self-disallows costs in the cost report in a good faith effort to comply with medicare rules, the PRRB may assume jurisdiction to hear the issues raised thereby;

2. The court finds persuasive the rationale provided by Judge Aronovitz in *Parkway Medical Center, et al. v. Heckler*, Case Number 83-1700-CIV (S.D. Fla. 9/24/85), and by the Seventh Circuit in *St. Mary of Nazarene Hospital Center v. Department of H.H.S.*, 698 F.2d 1337, *cert. denied* 104 S.Ct. 107 (1983).

3. This court believes that the motion to dismiss should be GRANTED without prejudice, and the cause be REMANDED to the PRRB for a hearing on the issue of allowance of the tax assessor and collection charges which had been listed in the 1977 reports.

DONE AND ORDERED at Miami, Florida this 2 day of September, 1985.

/s/ ALCEE L. HASTINGS
*United States District Judge*

Copies:
Richard C. Klugh, Jr., Esq.
Susan H. Aprill, Esq. (AUSA)

# United States District Court

SOUTHERN DISTRICT OF FLORIDA

CASE NO. 84-6737-Civ-HASTINGS

NORTH BROWARD HOSPITAL DISTRICT,

v.

MARGARET M. HECKLER.

REPORT AND RECOMMENDATION

(Filed, August 2, 1985)

This is a review of a final decision by the Secretary of Health and Human Services denying reimbursement for certain costs to three hospitals owned and operated by the Plaintiff—Broward General Medical Center, North Broward General Medical Center and Imperial Point Medical Center. Each of these hospitals is a Medicare "Provider" within the meaning of the Act, 42 U.S.C. §§ 1395, *et. seq.*

Plaintiff asserts jurisdiction based upon 42 U.S.C. § 1395oo(f). Defendant contests subject-matter jurisdiction, and has moved to dismiss or alternatively for summary judgment. Plaintiff has responded by Memorandum. The issue is now ripe for determination.

The case has been referred for preliminary review and report. For reasons given below, it is Recommended that the Motion to Dismiss be Denied.

## FACTS ALLEGED

Under Rule 12(b), allegations of the Complaint are taken as true for purposes of ruling upon a motion to dismiss. Accordingly, this matter is determined on the following facts.

Each of the three hospitals filed a "cost report" for 1977 as required by the Medicare Act, 42 U.S.C. § 1395oo(f) and regulations. These reports must be filed after the end of a fiscal year and must reflect the actual cost of services incurred that year. From these reports, the "fiscal intermediary" who

administers Medicare determines the actual reimbursement which the provider will get. If the provider disagrees with that determination, it can appeal to the Provider Reimbursement Review Board (PRRB). 45 C.F.R. §§ 405.1835 and 1841. Final administrative determination rests with Health Care Financing Administration. 42 U.S.C. § 1395oo(f)(l). Judicial review is then appropriate. 42 U.S.C. § 1395oo.

In 1977, the hospitals here involved filed cost reports in which they "disallowed" charges by the Broward County Tax Assessor and Tax Collectór. They "self-disallowed" these costs based upon rules and regulations of the Secretary which were later declared invalid or inapplicable.

These hospitals requested a hearing before the PRRB on the issue of allowance of the tax assessor and collection charges which had not been listed in the 1977 reports. On April 1, 1983 the PRRB advised that it would take jurisdiction and consider these issues. (See Administrative Record at 41, 43, 45). A decision was rendered on June 28, 1984 by the PRRB in which it reconsidered and determined that it had no jurisdiction. This determination rested upon the Board's interpretation of its jurisdictional grant, 42 U.S.C. § 1395oo(d). The Board concluded that the statute required "overt disclosure" of the disputed issue "ordinarily evidenced by claiming reimbursement for the particular items in the cost report." (See Ex. A, attached to Complaint). Because the providers had "self-disallowed," the Board reasoned, they had not put the tax charges in issue. The Health Care Financing Administration affirmed. This became the final decision of the Secretary.

## ISSUES

Defendant has raised two issues: First, whether Plaintiff has standing to bring this action. Second, whether this Court lacks jurisdiction to review a provider's claim for Medicare expenses where the provider self-disallowed those expenses in its cost report and the PRRB held that it was without jurisdiction to hear such a claim.

The first issue is readily disposed of. Defendant argues that Plaintiff is not technically a "provider" within the meaning of

42 U.S.C. § 1395x(v).[1] Only "providers," it argues, can seek judicial review. 42 U.S.C. § 1395oo(f). Defendant points to a medicare program manual (The Provider Reimbursement Manual § 2150 which indicates that entities like Plaintiff are a "related organization" and not a "provider."

Defendant has cited no cases in support of her argument that Plaintiff lacks standing. In *Valley View Community Hospital v. United States*, 679 F.2d 857 (Ct. C1. 1982) this issue was addressed. The Court held that a "related organization" had standing to challenge the denial of Medicare reimbursement to the provider hospitals which it owned, 679 F.2d at 860. Obviously, denial of the provider's claim will adversely affect its owner.

The second issue is more complex but is readily resolved in Plaintiff's favor.

In essence, Defendant argues that where a provider does not claim a specific expense in a cost report but instead eliminates that expense in its belief that it is non-reimbursable, then the provider has made no "overt disclosure" and has accordingly failed to put the expense in issue. The PRRB only has jurisdiction to review "matters covered by such cost report . . ." 42 U.S.C. § 1395oo(d). Since an expense which is not *overtly* disclosed is not "covered" in the report, the Defendant argues, the PRRB has no jurisdiction. Thus, if a claim was not specifically raised in the report it cannot be appealed administratively and, accordingly, judicial review is foreclosed. This position is supported by *Athens Community Hospital v. Schweiker*, 743 F.2d. (D.C.Cir. 1984) and *Saline Community Hospital v. Sec'y of Health & Human Services*, 744 F.2d.517 (6th Cir. 1984).

Having carefully considered defendant's argument and the cited authorities, I Recommend, for the reasons given therein, that the Court adopt the holding of *Parkway Medical Center, et al. v. Heckler*, No. 83-1700-Civ-ARONOVITZ (S.D. Fla. Sept. 24, 1984).

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[1] The statute states: "The term 'provider of services' means a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency, hospice program, or, for purposes of section 1395f(g) and section 1395n(e) of this title, a fund."

In *Parkway,* Judge Aronovitz denied a motion to dismiss brought on identical grounds. He reasoned that providers which "self-disallow" are merely attempting to comply with the law and indeed are under possible criminal penalty for fraud if they claim in their cost reports expenses which are (at the time) prohibited by law from reimbursement. The Court concluded that it is entirely reasonable for a provider to disallow in compliance with Medicare Rules and later raise the pertinent issue to the PRRB.

The Court also relied upon *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337 (7th Cir.), *cert. denied*, U.S. , 104 S.Ct. 107 (1983). *St. Mary* held that under § 1395oo(d) the PRRB is empowered to consider matters *outside* the reports. 698 F.2d at 1346.[2]

In sum, it is the conclusion of the undersigned based upon *Parkway* and the cases considered therein that where a provider self-disallows costs in the cost report in a good faith effort to comply with Medicare rules, the PRRB has jurisdiction to hear and indeed must hear issues otherwise properly raised regarding such costs. Defendant's Motion, therefore, should be DENIED.

Pursuant to 28 U.S. C. § 636 (b)(1), the parties may serve and file written objections to this Recommendation with the Honorable Alcee L. Hastings, United States District Judge, within ten (10) days after being served with a copy thereof.

In Miami, Florida, August 2, 1985.

/s/ PETER L. NIMKOFF
*United States Magistrate*

Copies:
Richard C. Klugh, Jr., Esq.
Patricia D. Kenny, AUSA

[2] In the case at bar, the PRRB originally took jurisdiction of the disputed issues. It then declined jurisdiction believing it was bound by *Athens.*

# *Health Care Financing Administration*

## *Decision of the Administrator*

**In the Case of:**

BROWARD GENERAL MEDICAL CENTER
AND
NORTH BROWARD GENERAL MEDICAL CENTER
*Provider*

*vs.*

BLUE CROSS OF FLORIDA, INC.
*Intermediary*

**Claim for:**

Provider Cost Reimbursement Determination of Reasonable Costs for Cost Reporting Period(s) Ending June 30, 1977

**Review of:**

PRRB Decision No.
Case Nos. 80-429 & 80-430
Dated: June 28, 1984

(Issued August 23, 1984)

These cases are before the Deputy Administrator, Health Care Financing Administration, for review of the decisions entered on June 28, 1984, by the Provider Reimbursement Review Board. As these cases involve identical issues of law and are based on similar undisputed material facts, the Deputy Administrator has consolidated these two cases for purposes of this review. The review is during the 60-day period in Section 1878(f) of the Social Security Act, as amended [42 USC 1395oo]. Comments were received from the Providers seeking reversal of the Board's decisions denying the Providers hearings on certain issues in these cases. The parties were notified that these cases would before the Deputy Administrator and of their right to submit comments during the course of this review. The Intermediary submitted comments requesting the Board decisions be affirmed. Accordingly, these cases are now before the Deputy Administrator for final administrative decision.

The entire record which was furnished by the parties has been examined. The Board's decisions have been carefully reviewed by the Deputy Administrator. All comments received after entry of the Board's decisions have been made a part of the record and considered. The statement of facts set forth by the Board in its decisions is incorporated by reference.

The Board denied jurisdiction of the tax assessment and tax collection issues for the Providers' 1977 cost years on the basis that the Providers had not claimed such costs in their respective cost reports and the Intermediary had made no adjustments pertaining to such issues. The Board relied upon the case of *Athens Community Hospital, Inc. v. Schweiker*, 686 F.2d 989 (D.C. Cir. 1982), which held that the Board does not have jurisdiction to hear issues arising out of claims which were not made on the cost report.

The Providers do not contest the fact that they did not claim reimbursement for the assessment and collection costs on their 1977 cost report and that the Intermediary made no adjustments pertaining to these costs for this year. However, they disagree with the Board's reliance upon *Athens*, and suggest that the proper rule was expressed in the cases of *St. Mary of Nazareth Hospital Center v. HHS*, 698 F.2d 1337 (7th Cir. 1983) and *Community Hospital of Roanoke Valley v. Heckler*, Medicare and Medicaid Guide (CCH), paragraph 33,954 (W.D. Va. Apr. 24, 1984). The Providers also suggest that dictum in *Athens* based on a distinction of factual situations renders *Athens* inapposite. As further support, the Providers point to the Board's initially having taken jurisdiction over their 1977 appeals.

The Intermediary merely reiterated its objection to the Board's hearing these issues and emphasized the longstanding nature of its objection.

After review of the Board's decisions and the parties comments, the Deputy Administrator finds that the Board acted reasonably in declining to take jurisdiction over the Providers' appeal of these issues in their 1977 cost reports. The Deputy

Administrator believes that the reasoning of the *Athens* case is controlling here.

This case can be distinguished from the *Athens* case on the facts. In the instant case, the provider included the cost in its cost report and then subtracted it as an unallowable cost from its claim for reimbursement (herein "self-disallowed cost"). In the *Athens* case, the provider did not report the cost at all in its cost report (herein "unreported cost"). However, this is a distinction without significance. The result of each situation is that the provider has not made a claim for reimbursement based on such cost and that the intermediary has had no reason to scrutinize the claim and supporting records.

The *Athens* court considered the significance of such a distinction. It noted two earlier district court cases relied upon by the provider in that case. The court pointed out that these cases could not be relied upon as precedential support because they were factually distinguishable in that they concerned self-disallowed costs rather than unreported costs. However, the court then gave its opinion that such distinction was meaningless and stated that it would adhere to its conclusion even it the cases were not distinguishable. 686 F.2d at 997. The court then supported its holding with policy reasons applicable to either situation: permitting de novo claims before the PRRB would make the PRRB the tribunal of original jurisdiction thereby eliminating a tier of review; the reimbursement process could be slowed for others; the time limits for filing cost reports would be rendered meaningless; and baseless appeals would be encouraged. The Deputy Administrator believes the reasons cited by the *Athens* court are valid regardless of whether the costs are self-disallowed or unreported.

The Deputy Administrator notes the Providers' contentions that the *Athens* holding was specifically rejected by the courts in *St. Mary of Nazareth Hospital Center*, *supra*, and *Community Hospital of Roanoke Valley*, *supra*. The Deputy Administrator does not agree that these courts rejected *Athens*, for their decisions failed to mention, explain, or distinguish *Athens*. The Deputy Administrator believes the

*Athens* court has given a better interpretation of the governing law. As this interpretation is consistent with Medicare policy, he will follow the *Athens* decision.

The Deputy Administrator also notes the Board's change of position from originally agreeing to hear the subject issues to later ruling it lacks jurisdiction to do so. The Deputy Administrator finds no error in the Board's decision to bring its position into conformity with the law. Accordingly, the decisions of the Provider Reimbursement Review Board denying jurisdiction in the cases are affirmed.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES**

/s/ JAMES L. SCOTT

James L. Scott
*Acting Deputy Administrator*
HEALTH CARE FINANCING ADMINISTRATION

Date: 8/23/84

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**PROVIDER REIMBURSEMENT REVIEW BOARD**
**6660 Security Boulevard**
**Baltimore, Maryland 21207**

June 28, 1984

**REFER TO**
CBE: 80-430

**Location: Professional Bldg.**
**Room 104**

Certified Mail

Barry G. Craig, Esquire
Mershon, Sawyer, Johnston,
Dunwody and Cole
1600 Southeast Bank Building
Miami, Florida 33131

Dear Mr. Craig:

Re: North Broward General Medical Center, Pompano Beach, Florida, Provider No. 10-0086, Case No. 80-430, F/Y/E's—June 30, 1977 and 1978.

The Board has reviewed the record in the above-captioned case and finds there is no jurisdictional authority concerning the issues in the 1977 cost year. This finding is based upon the fact that the costs for the tax assessment and tax collection issues were not claimed in the Provider's cost report(s); nor have any amended cost report(s) been accepted by the Intermediary on these issues; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue.

Although there was an earlier indication these issues may be permitted since there were other issues appealed, the Board finds such action was not consistent with the Court of Appeals case of *Athens Community Hospital, Inc., v. Schweiker*, United States Court of Appeals for the District of Columbia Circuit, 686 F.2d 989 (D.C., Cir. 1982).

The statute and regulations require as a prerequisite for an appeal that the provider must be dissatisfied with its intermediary's final determination. The provider must have made an overt disclosure of its posture on a particular issue which is ordinarily evidenced by claiming reimbursement for the particular item in the cost report which the intermediary may

then adjust in whole or in part. Self-disallowed cost situations present a special problem because unless there is some clear overt disclosure (notice) of its disagreement on a particular item, there is no method for creating a controversy as required by the statute regulations.

In this case, the Provider self-disallowed these costs and did not make any other specific claim for the costs. As a result, there was no Intermediary adjustment reflected in its Notice of Program Reimbursement, nor have any amended cost reports been accepted by the Intermediary. Since there has been no Intermediary determination, or claim made in the filed cost reports, or overt notice given at the time they were filed of any disagreement with a reimbursement policy, etc., there is no controversy for the Board to exercise its jurisdiction. (See enclosure for a further detailed explanation of this denial).

In view of the foregoing reasons, the Board must deny jurisdiction for the above-stated issues for the 1977 cost year in the above-captioned case. This determination is subject to the provisions of 42 CFR 405.1875 and 1877, (Section 1878(f) of the Act).

Board Members Participating:

Paul Morton Ganeles
Richard A. Dudgeon
Barbara J. Sinnott
Edward A. Hofler
Thomas F. Clinton, Jr.

FOR THE BOARD:

PAUL MORTON GANELES
*Chairman*

Enclosure
PRRB Supplemental Explanation for
Denial of Jurisdiction
Regulations 42 CFR 405.1875 and 1877

cc:
Mrs. Elaine C. Powell, Blue Cross of Florida, Inc.

## PROVIDER REIMBURSEMENT REVIEW BOARD SUPPLEMENTAL EXPLANATION FOR DENIAL OF JURISDICTION

Pursuant to the controlling law and regulations (42 USC section 1395oo and 42 CFR 405, subpart R), the Board is empowered to review and hold hearings concerning a final Notice of Program Reimbursement (NPR) determination of fiscal intermediaries regarding cost reimbursement matters. The jurisdictional requirements to secure a Board hearing are set forth in 42 USC section 1395oo(a) and (b). Section (a) provides that:

> "... Any provider of services which has filed a required cost report ... may obtain a hearing with respect to such cost report ... if—such provider—is dissatisfied with a final determination ... of its fiscal intermediary ...."

The regulation, 42 CFR 405.1839(a), provides the methodology of determining the amount in controversy as follows:

> "The ... *amount in controversy* will be computed by deducting the adjusted total reimbursable program costs from the total reimbursable cost ... *claimed* by the provider." (Emphasis added)

The cited statutory provisions entitle a provider to a Board hearing only with respect to a cost report which was filed in compliance with the rules and regulations of the Secretary. Such hearing is limited to disputed issues included in the intermediary's final determination (NPR) on matters covered by such cost report, or where there has been an overt disclosure of a particular disputed item when the cost report was filed.

The regulations require that, as a condition precedent, the provider must have claimed the cost in its final cost report to give rise to any controversy. The Provider may also preserve appeal rights by filing a clear overt disclosure of its disagreement for a particular disputed item(s) which may relate to such matters as certain self-disallowed or unclaimed costs. When the provider files a cost report, it must either claim the

particular cost or state its claim and disclose its position on an issue so the intermediary can consider and make a final determination. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction. The Board's jurisdiction flows from the intermediary's NPR with respect to the filed cost report and the disputes arising from costs claimed and/or any clear disclosure or a particular disputed item with the filed cost report.

The statute does not entitle a provider to claim additional reimbursement for a particular cost reporting period after filing its cost report or after receiving the intermediary's final determination (NPR). However, once a cost report is filed, the regulations provide that any amendments to the cost report "... may be permitted or required as determined by the Health Care Financing Administration, ....", 42 CFR section 405.453(f). HCFA policy instructions stated in Pt. 2—Part A Intermediary Manual, section 2631.2 (HIM 13-2), contains the criteria in the limited situations where the intermediary may accept an amended cost report. "Whether or not the Intermediary will reopen a determination ... which is otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations, or guidelines." Once an intermediary has issued a final determination (NPR) regarding a provider's filed cost report, a cost report may only be amended if the intermediary "reopens" its final determination. Accordingly, the reopening provisions of the regulations are controlling, 42 CFR section 405.1885(a). Reopenings are allowed only to hear new evidence—not new claims.

Section 405.1885(c) states that jurisdiction for such reopenings rests exclusively with that administrative body that rendered the last determination (which in this case was the intermediary), and such decisions are not appealable to the PRRB.

Thus, the above authorities provide: (1) that the acceptance of an amended cost report is within the discretion of the intermediary, and (2) that once an NPR has been issued, then

the reopening (including through an amended cost report) is within the exclusive jurisdiction of the intermediary which is not appealable per se. The Board's jurisdiction flows from the cost report or amended cost report and the related NPR or revised NPR. There must have been a claim on the cost report (or amended cost report) or other overt disclosure made with the cost report that ultimately gives rise to the disagreement. Thus, Board jurisdiction is limited to those cases in which a provider has claimed a reimbursement amount and the intermediary has denied that claim in full or in part, or where the provider has made a proper overt disclosure (notice) of its posture (disagreement) on a particular issue.

No consideration will be given to a request for a hearing which does not comply with the foregoing requirements. No expansion of the scope of the appeal or the hearing will be allowed to include any issue or amount not originally claimed or disclosed in the filed cost report.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**PROVIDER REIMBURSEMENT REVIEW BOARD**
**6560 Security Boulevard**
**Baltimore, Maryland 21207**

June 28, 1984

**REFER TO**
CBE:80-429

**Location: Professional Bldg. Room 104**

Certified Mail

Barry G. Craig, Esquire
Mershon, Sawyer, Johnston,
Dunwody and Cole
1600 Southeast Bank Building
Miami, Florida 33131

Dear Mr. Craig:

Re: Broward General Medical Center, Fort Lauderdale, Florida, Provider No. 10-0039, Case No. 80-429, F/Y/E's—June 30, 1977 and 1978

The Board has reviewed the record in the above-captioned case and finds there is no jurisdictional authority concerning the issues in the 1977 cost year. The finding is based upon the fact that the costs for the tax assessment and tax collection issues were not claimed in the Provider's cost report(s); nor have any amended cost report(s) been accepted by the Intermediary on these issues; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue.

Although there was an earlier indication these issues may be permitted since there were other issues appealed, the Board finds such action was not consistent with the Court of Appeals case of *Athens Community Hospital, Inc., v. Schweiker,* United States Court of Appeals for the District of Columbia Circuit, 686 F.2d. 989 (D.C., Cir. 1982).

The statute and regulations require as a prerequisite for an appeal that the provider must be dissatisfied with its intermediary's final determination. The provider must have made an overt disclosure of its posture on a particular issue which is ordinarily evidenced by claiming reimbursement for the particular item in the cost report which the intermediary may

then adjust in whole or in part. Self-disallowed cost situations present a special problem because unless there is some clear overt disclosure (notice) of its disagreement on a particular item, there is no method for creating a controversy as required by the statute regulations.

In this case, the Provider self-disallowed these costs and did not make any other specific claim for the costs. As a result, there was no Intermediary adjustment reflected in its Notice of Program Reimbursement, nor have any amended cost reports been accepted by the Intermediary. Since there has been no Intermediary determination, or claim made in the filed cost reports, or overt notice given at the time they were filed of any disagreement with a reimbursement policy, etc., there is no controversy for the Board to exercise its jurisdiction. (See enclosure for a further detailed explanation of this denial.)

In view of the foregoing reasons, the Board must deny jurisdiction for the above-stated issues for the 1977 cost year in the above-captioned case. This determination is subject to the provisions of 42 CFR 405.1875 and 1877, (Section 1878(f) of the Act).

Board Members Participating:

Paul Morton Ganeles
Richard A. Dudgeon
Barbara J. Sinnott
Edward A. Hofler
Thomas F. Clinton, Jr.

FOR THE BOARD:

PAUL MORTON GANELES
*Chairman*

Enclosure
PRRB Supplemental Explanation for
Denial of Jurisdiction
Regulations 42 CFR 405.1875 and 1877

cc:
Mrs. Elaine C. Powell, Blue Cross of Florida, Inc.

## PROVIDER REIMBURSEMENT REVIEW BOARD SUPPLEMENTAL EXPLANATION FOR DENIAL OF JURISDICTION

Pursuant to the controlling law and regulations (42 USC section 1395oo and 42 CFR 405, subpart R), the Board is empowered to review and hold hearings concerning a final Notice of Program Reimbursement (NPR) determination of fiscal intermediaries regarding cost reimbursement matters. The jurisdictional requirements to secure a Board hearing are set forth in 42 USC section 1395oo(a) and (b). Section (a) provides that:

> "... Any provider of services which has filed a required cost report ... may obtain a hearing with respect to such cost report ... if—such provider—is dissatisfied with a final determination ... of its fiscal intermediary ...."

The regulation, 42 CFR 405.1839(a), provides the methodology of determining the amount in controversy as follows:

> "The ... *amount in controversy* will be computed by deducting the adjusted total reimbursable program costs from the total reimbursable cost ... *claimed* by the provider." (Emphasis added)

The cited statutory provisions entitle a provider to a Board hearing only with respect to a cost report which was filed in compliance with the rules and regulations of the Secretary. Such hearing is limited to disputed issues included in the intermediary's final determination (NPR) on matters covered by such cost report, or where there has been an overt disclosure of a particular disputed item when the cost report was filed.

The regulations require that, as a condition precedent, the provider must have claimed the cost in its final cost report to give rise to any controversy. The Provider may also preserve appeal rights by filing a clear overt disclosure of its disagreement for a particular disputed item(s) which may relate to such matters as certain self-disallowed or unclaimed costs. When the provider files a cost report, it must either claim the

particular cost or state its claim and disclose its position on an issue so the intermediary can consider and make a final determination. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction. The Board's jurisdiction flows from the intermediary's NPR with respect to the filed cost report and the disputes arising from costs claimed and/or any clear disclosure or a particular disputed item with the filed cost report.

The statute does not entitle a provider to claim additional reimbursement for a particular cost reporting period after filing its cost report or after receiving the intermediary's final determination (NPR). However, once a cost report is filed, the regulations provide that any amendments to the cost report "... may be permitted or required as determined by the Health Care Financing Administration, ....", 42 CFR section 405.453(f). HCFA policy instructions stated in Pt. 2—Part A Intermediary Manual, section 2631.2 (HIM 13-2), contains the criteria in the limited situations where the intermediary may accept an amended cost report. "Whether or not the Intermediary will reopen a determination ... which is otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations, or guidelines." Once an intermediary has issued a final determination (NPR) regarding a provider's filed cost report, a cost report may only be amended if the intermediary "reopens" its final determination. Accordingly, the reopening provisions of the regulations are controlling, 42 CFR section 405.1885(a). Reopenings are allowed only to hear new evidence—not new claims.

Section 405.1885(c) states that jurisdiction for such reopenings rests exclusively with that administrative body that rendered the last determination (which in this case was the intermediary), and such decisions are not appealable to the PRRB.

Thus, the above authorities provide: (1) that the acceptance of an amended cost report is within the discretion of the intermediary, and (2) that once an NPR has been issued, then

the reopening (including through an amended cost report) is within the exclusive jurisdiction of the intermediary which is not appealable per se. The Board's jurisdiction flows from the cost report or amended cost report and the related NPR or revised NPR. There must have been a claim on the cost report (or amended cost report) or other overt disclosure made with the cost report that ultimately gives rise to the disagreement. Thus, Board jurisdiction is limited to those cases in which a provider has claimed a reimbursement amount and the intermediary has denied that claim in full or in part, or where the provider has made a proper overt disclosure (notice) of its posture (disagreement) on a particular issue.

No consideration will be given to a request for a hearing which does not comply with the foregoing requirements. No expansion of the scope of the appeal or the hearing will be allowed to include any issue or amount not originally claimed or disclosed in the filed cost report.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**PROVIDER REIMBURSEMENT REVIEW BOARD**
**6660 Security Boulevard**
**Baltimore, Maryland 21207**

June 28, 1984

**REFER TO**
CBE:80-431

**Location: Professional Bldg.**
**Room 104**

Certified Mail

Barry G. Craig, Esquire
Mershon, Sawyer, Johnston,
Dunwody and Cole
1600 Southeast Bank Building
Miami, Florida 33131

Dear Mr. Craig:

Re: Imperial Point Hospital, Fort Lauderdale, Florida, Provider No. 10-0200, Case No. 80-431, F/Y/E's—June 30, 1977 and 1978

The Board has reviewed the record in the above-captioned case and finds there is no jurisdictional authority concerning the issues in the 1977 cost year. The finding is based upon the fact that the costs for the tax assessment and tax collection issues were not claimed in the Provider's cost report(s); nor have any amended cost report(s) been accepted by the Intermediary on these issues; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue.

Although there was an earlier indication these issues may be permitted since there were other issues appealed, the Board finds such action was not consistent with the Court of Appeals case of *Athens Community Hospital, Inc., v. Schweiker,* United States Court of Appeals for the District of Columbia Circuit, 686 F.2d. 989 (D.C., Cir. 1982).

The statute and regulations require as a prerequisite for an appeal that the provider must be dissatisfied with its intermediary's final determination. The provider must have made an overt disclosure of its posture on a particular issue which is ordinarily evidenced by claiming reimbursement for the particular item in the cost report which the intermediary may

then adjust in whole or in part. Self-disallowed cost situations present a special problem because unless there is some clear overt disclosure (notice) of its disagreement on a particular item, there is no method for creating a controversy as required by the statute regulations.

In this case, the Provider self-disallowed these costs and did not make any other specific claim for the costs. As a result, there was no Intermediary adjustment reflected in its Notice of Program Reimbursement, nor have any amended cost reports been accepted by the Intermediary. Since there has been no Intermediary determination, or claim made in the filed cost reports, or overt notice given at the time they were filed of any disagreement with a reimbursement policy, etc., there is no controversy for the Board to exercise its jurisdiction. (See enclosure for a further detailed explanation of this denial).

In view of the foregoing reasons, the Board must deny jurisdiction for the above-stated issues for the 1977 cost year in the above-captioned case. This determination is subject to the provisions of 42 CFR 405.1875 and 1877, (Section 1878(f) of the Act).

Board Members Participating:

Paul Morton Ganeles
Richard A. Dudgeon
Barbara J. Sinnott
Edward A. Hofler
Thomas F. Clinton, Jr.

FOR THE BOARD:

PAUL MORTON GANELES
*Chairman*

Enclosure
PRRB Supplemental Explanation for
Denial of Jurisdiction
Regulations 42 CFR 405.1875 and 1877

cc:
Mrs. Elaine C. Powell, Blue Cross of Florida, Inc.

## PROVIDER REIMBURSEMENT REVIEW BOARD SUPPLEMENTAL EXPLANATION FOR DENIAL OF JURISDICTION

Pursuant to the controlling law and regulations (42 USC section 1395oo and 42 CFR 405, subpart R), the Board is empowered to review and hold hearings concerning a final Notice of Program Reimbursement (NPR) determination of fiscal intermediaries regarding cost reimbursement matters. The jurisdictional requirements to secure a Board hearing are set forth in 42 USC section 1395oo(a) and (b). Section (a) provides that:

> "... Any provider of services which has filed a required cost report ... may obtain a hearing with respect to such cost report ... if—such provider—is dissatisfied with a final determination ... of its fiscal intermediary ...."

The regulation, 42 CFR 405.1839(a), provides the methodology of determining the amount in controversy as follows:

> "The ... *amount in controversy* will be computed by deducting the adjusted total reimbursable program costs from the total reimbursable cost ... *claimed* by the provider." (Emphasis added)

The cited statutory provisions entitle a provider to a Board hearing only with respect to a cost report which was filed in compliance with the rules and regulations of the Secretary. Such hearing is limited to disputed issues included in the intermediary's final determination (NPR) on matters covered by such cost report, or where there has been an overt disclosure of a particular disputed item when the cost report was filed.

The regulations require that, as a condition precedent, the provider must have claimed the cost in its final cost report to give rise to any controversy. The Provider may also preserve appeal rights by filing a clear overt disclosure of its disagreement for a particular disputed item(s) which may relate to such matters as certain self-disallowed or unclaimed costs. When the provider files a cost report, it must either claim the

particular cost or state its claim and disclose its position on an issue so the intermediary can consider and make a final determination. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction. The Board's jurisdiction flows from the intermediary's NPR with respect to the filed cost report and the disputes arising from costs claimed and/or any clear disclosure or a particular disputed item with the filed cost report.

The statute does not entitle a provider to claim additional reimbursement for a particular cost reporting period after filing its cost report or after receiving the intermediary's final determination (NPR). However, once a cost report is filed, the regulations provide that any amendments to the cost report "... may be permitted or required as determined by the Health Care Financing Administration, ....", 42 CFR section 405.453(f). HCFA policy instructions stated in Pt. 2—Part A Intermediary Manual, section 2631.2 (HIM 13-2), contains the criteria in the limited situations where the intermediary may accept an amended cost report. "Whether or not the Intermediary will reopen a determination ... which is otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations, or guidelines." Once an intermediary has issued a final determination (NPR) regarding a provider's filed cost report, a cost report may only be amended if the intermediary "reopens" its final determination. Accordingly, the reopening provisions of the regulations are controlling, 42 CFR section 405.1885(a). Reopenings are allowed only to hear new evidence—not new claims.

Section 405.1885(c) states that jurisdiction for such reopenings rests exclusively with that administrative body that rendered the last determination (which in this case was the intermediary), and such decisions are not appealable to the PRRB.

Thus, the above authorities provide: (1) that the acceptance of an amended cost report is within the discretion of the intermediary, and (2) that once an NPR has been issued, then

the reopening (including through an amended cost report) is within the exclusive jurisdiction of the intermediary which is not appealable per se. The Board's jurisdiction flows from the cost report or amended cost report and the related NPR or revised NPR. There must have been a claim on the cost report (or amended cost report) or other overt disclosure made with the cost report that ultimately gives rise to the disagreement. Thus, Board jurisdiction is limited to those cases in which a provider has claimed a reimbursement amount and the intermediary has denied that claim in full or in part, or where the provider has made a proper overt disclosure (notice) of its posture (disagreement) on a particular issue.

No consideration will be given to a request for a hearing which does not comply with the foregoing requirements. No expansion of the scope of the appeal or the hearing will be allowed to include any issue or amount not originally claimed or disclosed in the filed cost report.

# In The United States Court of Appeals

FOR THE ELEVENTH CIRCUIT

No. 85-6039

(Filed February 25, 1987)

NORTH BROWARD HOSPITAL DISTRICT,
*Plaintiff-Appellee,*

*v.*

OTIS R. BOWEN, M.D., Secretary, of the Department of Health and Human Services,
*Defendent-Appellant.*

---

**Appeal from the United States District Court for the Southern District of Florida**

---

**ON PETITION FOR REHEARING AND SUGGESTION FOR REHEARING EN BANC**

(Opinion January 12, 1987, 11 Cir., 1987, F.2d ).

(February 25, 1987)

Before JOHNSON and ANDERSON, Circuit Judges, and GARZA*, Senior Circuit Judge.

PER CURIAM:

( X ) The Petition for Rehearing is DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing *en banc* (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 26), the Suggestion for Rehearing En Banc is DENIED.

( ) The Petition for Rehearing is DENIED and the Court having been polled at the request of one of the members of the Court and a majority of the Circuit Judges who are in regular active service not having voted in favor of it (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 26), the Suggestion for Rehearing En Banc is also DENIED.

( ) A member of the Court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service not having voted in favor of it, rehearing en banc is DENIED.

ENTERED FOR THE COURT:

/s/ FRANK M. JOHNSON, JR.
United States, Circuit Judge

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* Honorable Reynaldo G. Garza, Senior U.S. Circuit Judge for the Fifth Circuit, sitting by designation.

# United States Court of Appeals

FOR THE ELEVENTH CIRCUIT

No. 85-6039

D. C. Docket No. 84-0737

(Issued March 6, 1987)

NORTH BROWARD HOSPITAL DISTRICT,
*Plaintiff-Appellee,*

*v.*

OTIS R. BOWEN, Secretary of the
Department of Health and Human Services,
*Defendant-Appellant.*

---

**Appeal from the United States District Court for the Southern District of Florida**

---

Before JOHNSON and ANDERSON, Circuit Judges, and GARZA*, Senior Circuit Judge.

JUDGMENT

This cause came on to be heard on the transcript of the record from the United States District Court for the Southern District of Florida, and was argued by counsel;

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be and the same is hereby, VACATED; and that this cause be and the same is hereby DISMISSED;

It is further ordered that each party bear their own costs on appeal.

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ANDERSON, Circuit Judge, concurred and filed an opinion.

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* Honorable Reynaldo G. Garza, Senior U.S. Circuit Judge for the Fifth Circuit, sitting by designation.

Entered: January 12, 1987
For the Court: Miguel J. Cortez, Clerk

By: /s/ DAVID MALAND
*Deputy Clerk*

Issued as Mandate Mar 06 1987

## STATUTE INVOLVED

42 U.S.C. § 1395oo. Provider Reimbursement Review Board.

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

* * *

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

* * *

(f)(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverse, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board or any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days from the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as

described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination in writing by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

* * *

Supreme Court, U.S.
FILED
AUG 17 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 86-1986

# In the Supreme Court of the United States

OCTOBER TERM, 1987

NORTH BROWARD HOSPITAL DISTRICT, PETITIONER

*v.*

OTIS R. BOWEN, SECRETARY
OF HEALTH AND HUMAN SERVICES

*ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT*

## BRIEF FOR THE RESPONDENT

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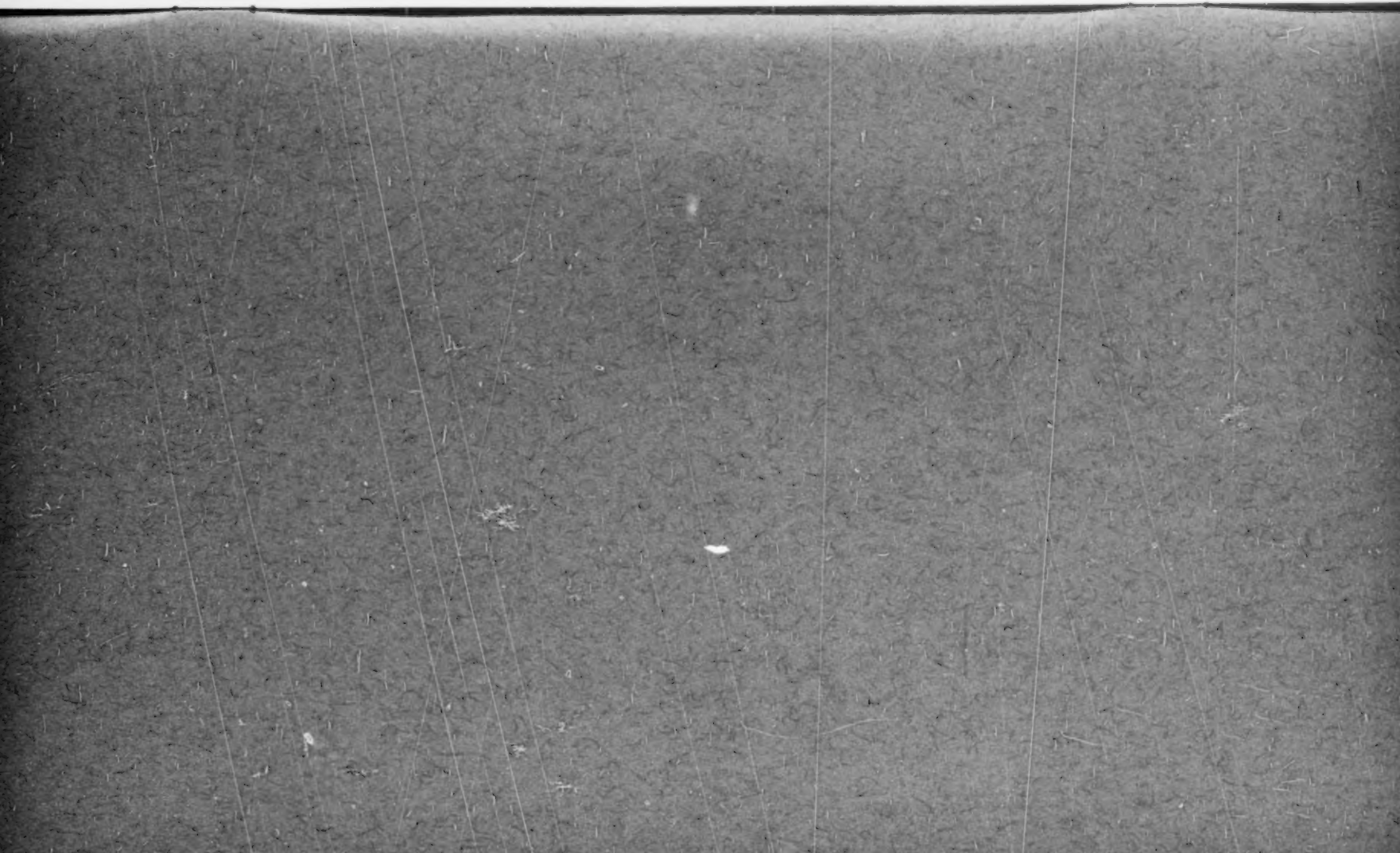

## QUESTION PRESENTED

Whether the Provider Reimbursement Review Board may consider a health care provider's claim that it is entitled to reimbursement under the Medicare statute for a particular cost when the provider failed to seek reimbursement for that cost from its fiscal intermediary and did not otherwise reserve before the intermediary its right to seek reimbursement for that cost.

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# In the Supreme Court of the United States

OCTOBER TERM, 1987

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No. 86-1986

NORTH BROWARD HOSPITAL DISTRICT, PETITIONER

*v.*

OTIS R. BOWEN, SECRETARY
OF HEALTH AND HUMAN SERVICES

---

*ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT*

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## BRIEF FOR THE RESPONDENT

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### OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A3-A10) is reported at 808 F.2d 1405. The order of the district court (Pet. App. A11-A12) is unreported. The opinion of the Deputy Administrator, Health Care Financing Administration (Pet. App. A17-A20), is unreported. The opinions of the Provider Reimbursement Review Board (Pet. App. A21-A35) are unreported.

### JURISDICTION

The judgment of the court of appeals (Pet. App. A37) was entered on January 12, 1987, and a petition for rehearing was denied on February 25, 1987 (Pet. App. A36). The petition for a writ of certiorari was filed on May 26, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

## STATEMENT

1. At the time of the events at issue in this case, all "providers" of health care services to Medicare beneficiaries were reimbursed by the Secretary of Health and Human Services on an annual basis for the "reasonable cost" of those health care services. 42 U.S.C. (& Supp. III) 1395f(b), 1395x(u) and (v)(1)(A).[1] Over the course of the year, the Secretary made payments to a provider based upon an estimate of the amounts owed to the provider. 42 U.S.C. 1395g; 42 C.F.R. 413.60. At the end of the year, the provider submitted a claim for reimbursement in the form of a "cost report." See 42 U.S.C. (& Supp. III) 1395f(a); 42 C.F.R. 413.20(a) and (b), 413.24(f).[2] The cost report is "a lengthy document consisting of numerous schedules, worksheets, and supplemental worksheets. * * * [A] cost report, when completed, is approximately three-quarters of an inch thick" (*Athens Community Hospital, Inc.* v. *Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984)). Providers list on the worksheets cost items for which they do not seek reimbursement because those cost items supply background information that supports the provider's cost claims.

The cost report is submitted to the provider's "fiscal intermediary" for review.[3] The intermediary audits the cost

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[1] These cases concern payments under "Part A" of the Medicare statute, which provides coverage for "the costs of hospital, related post-hospital, home health services, and hospice care" (42 U.S.C. 1395c).

[2] The report is due three months after the end of the provider's fiscal year. The provider may obtain a 30-day extension of the due date for "good cause." 42 C.F.R. 413.24(f)(2).

[3] The intermediary, which is generally a private insurance company, is an entity that, pursuant to a contract with the Secretary, acts as the Secretary's agent in reviewing the provider's claims and determining the amount of reimbursement owed to the provider. See 42 U.S.C. (& Supp. III) 1395h; 42 C.F.R. 421.3, 421.100-421.128.

report and issues a Notice of Program Reimbursement specifying the total amount of reimbursement due to the provider and explaining any adjustments to the costs claimed by the provider. See 42 C.F.R. 405.1803.[4]

If a provider has timely filed its cost report and is "dissatisfied with [the intermediary's] final determination * * * as to the amount of total program reimbursement due the provider" or has not received a final determination on a "timely basis," the provider "may obtain a hearing with respect to such cost report" before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. (& Supp. III) 1395*oo*(a)(1); see also 42 C.F.R. 405.1835.[5] The PRRB is authorized by statute (42 U.S.C. 1395*oo*(d)) to

> affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Board's decision is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. The Board's decision—or the Secretary's modified decision, if any—is subject to judicial review in federal district court pursuant to the Administrative Procedure Act. 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); 42 C.F.R. 405.1875-405.1877.

The statute establishes a second, more expeditious route into court in certain circumstances. A provider may obtain

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[4] The reimbursement award specified in the Notice of Program Reimbursement is compared to the Secretary's payments to the provider. Any deficiency is paid by the Secretary and any overpayment is repaid by the provider. 42 C.F.R. 405.1803(c), 413.60.

[5] Review by the PRRB is available only if the amount in controversy is $10,000 or more and the provider's request for a hearing is timely filed (42 U.S.C. (& Supp. III) 1395*oo*(a)(2) and (3)).

direct judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." 42 U.S.C. 1395*oo*(f)(1); see also 42 C.F.R. 405.1842.[6]

2. Petitioner, a special tax district created by the State of Florida, operates three public hospitals that are certified as providers of health services under the Medicare program. Petitioner's 1977 cost report listed certain charges imposed by the Broward County tax assessor and the Broward County tax collector in connection with the collection of the revenue needed to operate these hospitals, but petitioner did not seek reimbursement for these costs, *i.e.*, petitioner "self-disallowed" the costs. As the court of appeals observed, because petitioner's cost report "did not request reimbursement for its tax payments, the fiscal intermediary did not include the tax collection costs in its [Notice of Program Reimbursement], and there were no payments made to [petitioner] for the tax collection expenses." Pet. App. A5.

Petitioner appealed the intermediary's determination to the Provider Reimbursement Review Board and, while the appeal was pending, petitioner for the first time claimed that it was entitled to reimbursement for the tax collection expenses. The Board found that it had no jurisdiction over petitioner's claim (Pet. App. A21-A25, A26-A30, A31-A35).[7] It observed that "the costs for the tax assessment and tax collection issues were not claimed in the Provider's cost report(s); nor have any amended cost report(s) been accepted by the Intermediary on these issues; nor

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[6] A final decision may be reopened by the intermediary, the Board, or the Secretary in certain circumstances. See 42 C.F.R. 405.1885.

[7] The Board had initially indicated that it had jurisdiction over the claim (Pet. App. A21, A26, A31).

have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue" (*id.* at A21, A26, A31).

The Board stated that "[t]he statute and regulations require as a prerequisite for an appeal that the provider must be dissatisfied with its intermediary's final determination. The provider must have made an overt disclosure of its posture on a particular issue which is ordinarily evidenced by claiming reimbursement for the particular item in the cost report which the intermediary may then adjust in whole or in part" (Pet. App. A21-A22, A26-A27, A31-A32).[8] Because there was no determination of petitioner's cost claim by the intermediary, "no * * * claim made [by petitioner] in the filed cost reports, or overt notice given at the time they were filed of any disagreement with a reimbursement policy, etc.," there was "no controversy [over which] the Board [could] exercise its jurisdiction" (*id.* at A22, A27, A32). The Secretary's designee—the Deputy Administrator of the Health Care Financing Administration—affirmed the Board's determination (Pet. App. A17-A20).

Petitioner sought judicial review of the administrative determination, and the district court reversed (Pet. App. A11-A12). It stated that "[w]here a provider self-disallows costs in the cost report in a good faith effort to comply with medicare rules, the PRRB may assume jurisdiction to hear the issues raised thereby" (*id.* at A11).

3. The court of appeals, in turn, reversed the district court, and upheld the Board's determination that it lacked jurisdiction over petitioner's claims (Pet. App. A3-A10). As a threshold matter the court observed that the

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[8] The Board noted that "[s]elf-disallowed cost situations present a special problem because unless there is some clear overt disclosure (notice) of [the provider's] disagreement on a particular item, there is no method for creating a controversy as required by the statute [and] regulations" (Pet. App. A22, A27, A32).

Secretary's interpretation of the statute is entitled to "substantial deference" (*id.* at A6). It concluded that the Secretary's interpretation of the scope of the Board's jurisdiction is correct.

The court of appeals stated that "[t]he language of the statute is ambiguous as to whether the PRRB can consider reimbursement claims not disclosed in the cost report" (Pet. App. A8).[9] Relying upon the D.C. Circuit's decision in *Athens Community Hospital* v. *Schweiker*, 686 F.2d 989 (D.C. Cir. 1982) (*Athens I*), modified, 743 F.2d 1 (D.C. Cir. 1984) (Bork, J.) (*Athens II*), the court concluded that "[t]he only plausible construction of section 1395*oo*(d) requires that an expense be overtly disclosed and contested before the fiscal intermediary in order to be 'a matter covered by such report' and appealable before the PRRB; the Board may consider 'revisions' of the reimbursement of costs * * * [only to the extent that] such revisions '[are] necessary to accommodate other PRRB revisions of matters that were [expressly] claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB.' " Pet. App. A9 (quoting *Athens II*, 743 F.2d at 9).

The court stated that a contrary conclusion would "result in the elimination of the administrative review process clearly provided for in the Medicare statute and regulations" (Pet. App. A9). "A broader reading of PRRB jurisdiction, allowing any claim to be raised for the first time on appeal to the Board, 'would effectively nullify the

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[9] The court pointed out that while "the PRRB has the power only to review 'matters covered by such cost report,' " the statute "also provides that the [PRRB] shall base its decision upon 'the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board . . . even though such matters were not considered by the intermediary in making such final determination.' " Pet. App. A7-A8 (citations omitted).

language in the statute that limits the PRRB's authority to affirm, reverse or modify reimbursements to "matters covered by a cost report" ' and wreak havoc with the multi-tiered administrative appeals scheme" (*ibid.* (quoting *Athens II*, 743 F.2d at 6)). The court held that "a provider, to retain the right to appeal the decision on whether a cost is reimbursable, must either expressly request reimbursement for a cost item in its initial cost report or specifically contest the non-allowability of the item with its intermediary in or with the cost report" (Pet. App. A9).[10]

## ARGUMENT

The question presented in this case is the same as the question presented in *Bethesda Hospital Ass'n* v. *Bowen*, petition for cert. pending, No. 86-1764, *i.e.*, whether the Provider Reimbursement Review Board may consider a claim for reimbursement that was not raised before the fiscal intermediary.[11] Here, the court of appeals concluded that the Board's jurisdiction "is limited to matters put into dispute by the provider at the time the cost report is filed" (Pet. App. A9), the same rule adopted by the court of appeals in *Bethesda Hospital Ass'n*. As we discussed in our response to the certiorari petition

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[10] The court observed that alternative means exist by which providers can preserve a claim for reimbursement, such as by seeking to reopen a previously filed cost report or self-disallowing costs while "append[ing] a letter to the cost report stating that such voluntary self-disallowance was performed only to comply with regulations which the provider wished to challenge" (Pet. App. A9-A10 n.7).

Judge Anderson concurred in the judgment, concluding that "deference to the agency's construction is due" because it "is not so strained as to be unreasonable, arbitrary or capricious" (Pet. App. A10).

[11] We have served petitioner's counsel with a copy of our response to the petition in *Bethesda Hospital Ass'n*.

(at 7-11), in *Bethesda Hospital Ass'n*, that conclusion regarding the scope of the Board's jurisdiction is supported by the language and structure of the Medicare statute, and by significant practical considerations. For the reasons stated in that response, however, we have suggested that the Court should grant the petition for a writ of certiorari in *Bethesda Hospital Ass'n*.

## CONCLUSION

The petition for a writ of certiorari should be held and disposed of as appropriate in light of the disposition of *Bethesda Hospital Ass'n* v. *Bowen*, petition for cert. pending, No. 86-1764.

Respectfully submitted.

DONALD B. AYER
*Acting Solicitor General**
RICHARD K. WILLARD
*Assistant Attorney General*
ANTHONY J. STEINMEYER
JOHN P. SCHNITKER
*Attorneys*

AUGUST 1987

* The Solicitor General is disqualified in this case.

U.S. GOVERNMENT PRINTING OFFICE: 1987—181-483:40485